

## **INSTRUCTIONS FOR FILLING OUT PRE-REVIEW QUESTIONNAIRE (PRQ)**

The Nebraska Office of Emergency Health Systems Trauma Program is pleased that you wish to participate in the statewide trauma system. The Nebraska Statewide Trauma System is comprised of hospitals and clinics striving to improve trauma patient care. Through this system all facilities offering trauma care may become centers of excellence. Thank you for participating in this process.

In order to prepare for your on-site review, please complete this questionnaire. All answers should directly follow the questions. The entire questionnaire is available on the web in a downloadable format @ <http://dhhs.ne.gov/Pages/EHS-Statewide-Trauma-System-of-Care.aspx>. The PRQ can be completed electronically (preferred) or via hard copy. Note: If a hard copy is printed a color printer should be used so that information and questions printed in blue appear on the page to the applicant.

### **Return the completed questionnaire to:**

Sherri Wren  
EHS Trauma Program Manager  
Office of Emergency Health Systems  
P.O. Box 95026  
Lincoln, NE 68509-5026  
Phone: (402) 471-0539  
E-mail: [sherri.wren@nebraska.gov](mailto:sherri.wren@nebraska.gov)

**If you have questions or concerns while filling out the PRQ**, please contact:

State of Nebraska Trauma Nurse Specialist or your Regional Trauma Program Manager (please reference website list of Designated Trauma Centers on the website cited above for names and contact information).

### **I. PURPOSE:**

- A. The purpose of this questionnaire for Consultation Visits is:
  - 1. To provide your institution with an outline of what site visitors will be discussing with you.
  - 2. To provide the site reviewer with an outline of your hospital trauma program to be better able to help you improve trauma care.
- B. The purpose of this questionnaire for Designation Visits is to accurately reflect the structure of your hospital's trauma program so that the site reviewers have a preliminary understanding of your hospital's trauma capabilities.

### **II. GENERAL**

- A. Complete the PRQ as thoroughly as possible.
- B. To fill in check boxes, double click on box then click on "checked".
- C. Note that many questions have a "Yes" or "No" component followed by "please describe". Be brief but precise in describing your processes.
- D. Not all questions are directly related to a trauma center criteria but answers to these questions assist the reviewers in understanding your system. [Questions in blue are specific to required criteria.](#)
- E. Please do not hesitate to ask the State or your Regional Trauma Program Manager for assistance in answering questions if you are unsure what information is being sought.

### **III. DATA REPORTING:**

- A. You may not currently track these numbers. Your hospital's HIM/Medical Records Department should be able to supply you with this information.
- B. Data Range:
  - 1. Data range for reporting data is defined by current regulations and is as follows:  
ICD-9-CM diagnosis codes: Injury codes in the range of 800-959.9, 994.1 (drowning), 994.7 (asphyxiation & strangulation) or 994.8 (electrocution).

2. The above ICD 9 data range corresponds with the following ICD 10 codes currently used in most trauma registry systems:

**ICD-10 codes:**

S00-S99 with 7th character modifiers of A, B, or C ONLY (initial encounter)

T07 (unspecified multiple injuries)

T14 (injury of unspecified body region)

T20-T28 with 7th character modifier of A ONLY (initial encounter)

T30-T32 (burn by TBSA percentages)

T79.A1-T79.A9 with 7th character modifier of A ONLY (initial encounter)

**Exclude the following patients if the only injuries they have are:**

S00 (Superficial injuries of the head)

S10 (Superficial injuries of the neck)

S20 (Superficial injuries of the thorax)

S30 (Superficial injuries of the abdomen, pelvis, lower back and external genitals)

S40 (Superficial injuries of shoulder and upper arm)

S50 (Superficial injuries of elbow and forearm)

S60 (Superficial injuries of wrist, hand and fingers)

S70 (Superficial injuries of hip and thigh)

S80 (Superficial injuries of knee and lower leg)

S90 (Superficial injuries of ankle, foot and toes)

**C. Data Reporting Year:**

1. For all data reported in this questionnaire, use data for the last 12 months prior to time of review (for example, review date is June 1, 2018 so reporting year would be May 1, 2017 - April 1, 2018).
2. Data should not be earlier than 15 months prior to date of application.

**IV. EDUCATIONAL REQUIREMENTS**

- A. For all nursing and medical staff providers, educational requirements are required for staff who have been in your employ for one year or greater. New hires\* have one year to comply with regulations. You do not need to count new hires in your % totals.
- B. Nurses must have eight (8) hours of trauma continuing education every two (2) years. TNCC can count as eight of those hours in the two year timeframe in which the class was taken.
- C. Two of the eight hours every two years must be pediatric. This can be accomplished by successfully attending PALS or ENPC.
- D. \*Locum tenens providers and traveling nurses are not considered “new hires” and MUST meet educational requirements at time of hire.
- E. ATLS and TNCC must be current. There is no grace period.
- F. Educational requirements do not have to be met for first time designation but are encouraged.

**V. PRE-REVIEW DOCUMENT CHECKLIST (Include these documents and information when submitting your PRQ)**

**A. Hospital Information**

- ☐ Signed Application
- ☐ Hospital's Governing Body Resolution
- ☐ Medical Staff Resolution
- ☐ Organizational Chart

**B. Trauma Staff**

- ☐ Table A if applicable: Trauma Surgeons
- ☐ Job Description of Trauma Program Coordinator
- ☐ CV: Trauma Program Coordinator

- ☐ Job Description of Trauma Program Medical Director
- ☐ CV: Trauma Program Medical Director

**C. Anesthesia**

- ☐ Table B if applicable: Anesthesia

**D. Emergency Department**

- ☐ Table D: Emergency Department Equipment Check List
- ☐ Emergency Department Trauma Flow Sheet
- ☐ Table C: Physicians and APPs covering the Emergency Department

**E. Operating Room/PACU**

- ☐ Table E if applicable: OR/PACU Equipment Check List

**F. Performance Improvement**

- ☐ Written PI Plan
- ☐ PI Audit Filters
- ☐ Pediatric PI Audit Filters
- ☐ In-Patient PI Audit Filters (if applicable)

**G. Trauma Team**

- ☐ Trauma Activation Criteria
- ☐ Helicopter Activation Protocol if Applicable
- ☐ EMS Protocol for transfer to Regional Trauma Center if Applicable

**INSTRUCTIONS FOR DAY OF SITE REVIEW**

**Have the following information available at time of site review. Do NOT send with the application.**

**I. MEDICAL RECORDS**

- A. Chose approximately 20 charts from the reporting year and include:
  - 1. EMS run sheet
  - 2. ED Physician Notes
  - 3. Any Procedure Notes (intubation, chest tube insertion, etc.)
  - 4. Trauma Flowsheet or ED Nursing Notes
  - 5. Radiology Reports
  - 6. Laboratory Reports
  - 7. Progress Notes (if admitted to your hospital)
  - 8. Autopsy (if available)
  - 9. Any PI forms associated with the patient
- B. If there are not 20 charts in the reporting year, you may chose charts from the year prior to the reporting year.
- C. Categories of Charts:
  - 1. All Trauma Deaths
  - 2. Trauma Activations especially those with unstable vital signs or those requiring a procedure (such as intubation, chest tube placement)
  - 3. Patients not activated but transferred to a higher level of care due to positive CT findings.
  - 4. If you admit patients to your hospital, have two to three inpatient charts available.

**II. SPREADSHEETS/LOGS**

- A. For each of the following, please have a spreadsheet or log available that includes name of employee/provider, name of CE/CME activity attended, dates, number of hours of CE, ATLS/TNCC date of expiration. Please complete the spreadsheet with totals for each two year periods. (These are required for re-designation only)
  - 1. RN education
  - 2. Physician and Advanced Practice Provider (APP) ATLS and CME (if applicable)
- B. For each of the following, please have a spreadsheet or log available that includes Name of agency or group attending, dates, topics covered.
  - 1. EMS education
  - 2. Prevention Activities
- C. For Disaster Drills & Exercises, a spreadsheet or log documenting local and regional disaster drills with dates, type of drill and agencies involved.

**III. DOCUMENTS/INFORMATION**

- A. Statistics on Physician/APP Response Times to the ED for Trauma Activations
- B. Statistics on Response Times for General Surgeons to Trauma Activations (if applicable)
- C. Statistics on ED Provider Response Times (if response is from outside the hospital)
- D. Performance Improvement Committee: minutes and documents for reporting year.
- E. Trauma Peer Review Meeting: minutes for reporting year
- F. Trauma Performance Improvement Activities: include examples that demonstrate loop closure.
- G. Written APP Guidelines: covering when they must call the physician on call.
- H. Any other Written Guidelines pertaining to trauma patients (Examples include Cervical Spine Clearance, Anticoagulation reversal).

**IV. ROOM/PERSONNEL ARRANGEMENTS**

- A. Conference Room for Pre-Review Meeting/Lunch and Exit Interview:
  - 1. Attendance for these meetings should include:

- a. Trauma Medical Director
- b. Trauma Program Coordinator
- c. As available (but highly suggested)
  - CEO
  - CNO/DON
  - Managers of Laboratory/Blood Bank, Radiology, ED, Quality Office
  - EMS representatives (from agencies that transport to your hospital on routine basis)
  - Any other interested hospital personnel.

B. EMS Interview:

- 1. One room available immediately after the Pre-Review Meeting for the State EMS Representative to interview your local EMS agency representatives.

C. Hospital Tour:

- 1. The Trauma Program Coordinator should accompany the review team on the hospital tour.
- 2. Department Managers should return to their respective departments to be available when the review team arrives in their area.
- 3. The Trauma Medical Director and other hospital staff are welcome on the tour as their schedule allows but are not required.
- 4. While the Physician and Nurse Reviewers are touring the hospital, the State EMS representative will interview the EMS agencies.

D. Two separate rooms for:

- 1. PI Review (Nurse Reviewer and Trauma Program Coordinator, Quality Office Personnel if involved in Trauma PI)
- 2. Medical Records Review (Physician Reviewer and Medical Records/HIM personnel or other staff that can readily locate information in the medical record).

**STATE OF NEBRASKA  
PRE-REVIEW QUESTIONNAIRE  
BASIC TRAUMA CENTER**

**NAME OF HOSPITAL:**

**HOSPITAL ADDRESS:**

**Contact Person:**

**Email:**

**Telephone:**

**FAX:**

**I. PURPOSE OF SITE REVIEW**

**Level of Review**

- ☐ Consultation  
☐ Designation  
☐ Re-designation

**II. HOSPITAL INFORMATION**

**A. Describe your hospital including governance.** (i.e. Not-For-Profit, Private, Critical Access, City-Owned)

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**B. Hospital Beds**

Hospital Beds	Adult	Pediatric	Total
Licensed			
Beds Staffed			
Average Daily Census			

**C. Reporting Year**

From month/year:

To month/year:

**D. Attach a hospital organizational chart that clearly delineates trauma services reporting structure.**

**E. Hospital Commitment**

1. Is there a resolution within the past three years supporting the trauma center by the hospital's governing body? ☐ Yes ☐ No

If "Yes," attach the resolution to this application.

2. Is there a medical staff resolution within the past three years supporting the trauma center? ☐ Yes ☐ No

If "Yes," attach the resolution to this application.

3. Does your hospital have a designated Trauma Medical Director? ☐ Yes ☐ No

a. If yes,

Name:

- b. How long have they been in this position?
- c. Do they attend a minimum of 50% of Trauma Peer Review Meetings where patient care is discussed? ☐ Yes ☐ No
- d. Does the job description contain verbatim the required language? ☐ Yes ☐ No  
 (footnote # 5 from checklist)  
 Attach job description and CV to this application.
4. Does your hospital have a designated Trauma Program Coordinator/Manager? ☐ Yes ☐ No
- a. If yes,  
 Name:
- b. How long have they been in this position?
- c. Does the job description contain verbatim the required language? ☐ Yes ☐ No  
 (footnote # 6 from checklist)  
 Attach job description and CV to this application.
5. List specific budgetary support for the trauma program such as personnel, education, equipment:

### III. PRE-HOSPITAL SYSTEM

- A. Describe your EMS system including type and names of squad transporting to your facility.  
 (Place an X in each column that applies.)

Name of Squad	Medical Director	Advanced	Basic	QRT/first responders

- B. How are EMS personnel dispatched to the scene of an injury? (Check all that apply.)
- ☐ EMS Center or 911 Centers  
☐ Law Enforcement Agency  
☐ Fire Department  
☐ Other (Define.)
- C. Do your EMS squads have triage criteria for scene helicopter activation? ☐ Yes ☐ No  
 If yes, please attach if applicable.
- D. Do your EMS squads have triage criteria for direct transport to the regional trauma center? ☐ Yes ☐ No  
 If yes, please attach if applicable.

- E. Does your hospital currently participate in pre-hospital training and pre-hospital performance improvement (for example: run reviews)?** ☐ Yes ☐ No

If yes, please describe and have documentation available at the visit

- F. Does your hospital have a formal, fixed decontamination shower?** ☐ Yes ☐ No

1. If yes, where is it located?

2. If no, how do you perform decontamination?

- G. Does the hospital conduct disaster drills that include EMS?** ☐ Yes ☐ No

- H. Describe your hospital's participation in the local or regional disaster plan.**

(Please have a spreadsheet of disaster drills available at the visit.)

#### IV. TRAUMA CARE

**A. Trauma Response**

1. Do you have criteria for trauma activation? ☐ Yes ☐ No

If yes, attach written criteria to application

2. Do you have the activation criteria clearly posted in your hospital? ☐ Yes ☐ No

If yes, where is it posted?

☐ ED ☐ Nurses Station ☐ Other

3. Do local EMS services have a copy of your activation criteria? ☐ Yes ☐ No

4. Describe how your hospital gets notification from EMS of possible trauma activation.

5. Describe how your trauma team members are notified of an activation.

6. What personnel respond to trauma activation? Check all that apply.

Personnel	Responds	Expected response times
Advanced Practice Provider (APP)		
Family Practice Physician		
Emergency Physician		

General Surgeon		
Staff Nurses		
Emergency Department Nurses		
Respiratory Therapists		
X-ray Technologist		
CT Technologist		
Laboratory Technician		
CRNA		
Anesthesiologist		
Nursing Supervisor		
OR Nurse		
Chaplain		
Other		

4. Who has the authority to activate the trauma team?

- ☐ ED nurse  
☐ Physician  
☐ APP (Advanced Practice Practitioner)  
☐ EMS  
☐ Other:

5. Do you have documentation and statistics for response times to trauma activations?  
(If yes, please have available for review).

☐ Yes ☐ No

6. What percent of the time is the medical provider (Physician or APP) present in the ED within 30 minutes of arrival of the patient?

 %

7. Do you have Physician backup for APPs?

☐ Yes ☐ No

8. Do you have written guidelines for when the APP must notify the Physician?  
(If yes, please attach).

☐ Yes ☐ No

9. Are all of your ED providers current in Advanced Trauma Life Support (ATLS)?

☐ Yes ☐ No

10. Does the hospital stock anti-coagulant reversal agents?

☐ Yes ☐ No

If yes, List below:

11. Do you have any General Surgeons who are on staff and actively involved in trauma care?

☐ Yes ☐ No

If yes, please complete "Trauma Surgeon Chart" (Table A).

If yes, have they completed 16 hours of trauma CME in the last four years?

☐ Yes ☐ No

If yes, are they current in ATLS?

☐ Yes ☐ No

If yes, do they attend a minimum of 50% of Trauma Peer Review Meetings where patient care is discussed?

☐ Yes ☐ No

12. Do you have any Orthopedic Surgeons who are on staff and actively

☐ Yes ☐ No

involved in trauma care?

If yes, do they attend a minimum of 50% of Trauma Peer Review Meetings ☐ Yes ☐ No  
where patient care is discussed?

**C. Trauma/Hospital Statistical Data:**

1. Total number of ED trauma-related visits for reporting year:

<b>ED VISITS</b>	<b>TOTAL</b>
Transferred to another acute care hospital/burn center	
Died in ED	
Died in OR	
Admitted to your hospital	
Discharged from ED to home (include Skilled Nursing Facility (SNF) assisted living, jail, etc.)	
<b>Total</b>	

2. Total number of patients entered into registry for reporting year:

3. Total number of trauma team activations:

<b>LEVEL</b>	<b>TOTAL #</b>
Full	
Limited/Partial (if applicable)	

4. Describe patient categories for admission to your hospital (i.e. concussion, fractures, observation).

5. Describe how the Trauma Program Coordinator identifies trauma patients in your system.

**D. Trauma Transfers:**

1. What percent of patients who require transfer to another facility are transferred out within two hours of arrival (excluding isolated hip fractures)?

 %

2. Number of trauma patients transferred out of your hospital to another acute care hospital:

<b>BY AIR</b>	<b>BY GROUND</b>	<b>TOTAL</b>

3. Describe your process to transfer a trauma patient to a higher level trauma center including the names of trauma centers you utilize on a routine basis.

4. Does your hospital have written criteria that identifies patients who should be considered for transfer? ☐ Yes ☐ No

If yes, please attach to questionnaire:

**E. Anesthesia Services**

1. Does your hospital provide Anesthesia Services? ☐ Yes ☐ No  
If yes, check all that apply and fill out Anesthesia coverage (Table B).

☐ Anesthesiologist ☐ CRNA

2. If yes, do they participate in trauma care by responding to trauma activations? ☐ Yes ☐ No  
If they respond to trauma activations, do you have anesthesia services available 24 hours a day? ☐ Yes ☐ No

If yes:

☐ In-house after hours ☐ On-call from home after hours

3. Who intubates the patient if Anesthesia Services is not available?

**V. HOSPITAL FACILITIES**

**A. Emergency Department**

1. Do you have a designated Emergency Department Physician Director? ☐ Yes ☐ No

Name:

2. Describe your usual physician/APP coverage in your ED?

3. What is nursing staffing pattern to cover ED and what is the backup plan for multiple patients?

4. Does your ED have resuscitation equipment for all ages? ☐ Yes ☐ No

5. Does your hospital have a heliport or landing zone? ☐ Yes ☐ No

If yes, where is it located?

6. Attach a copy of ED trauma flow sheet or ED record.

7. Is Decision to Transfer time included on the trauma flow sheet? ☐ Yes ☐ No

8. Do 100% of nurses who cover ED have eight (8) hours trauma continuing education every two (2) years? ☐ Yes ☐ No

9. Are all RN's who cover the ED currently verified in TNCC?

☐ Yes ☐ No

If not 100%, what percentage is verified?

%
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10. Percent of nurses who are current in the following courses:

_____ %	Pediatric Advanced Life Support (PALS)
_____ %	Emergency Nurse Pediatric Course (ENPC)
_____ %	Advanced Trauma Care Nursing (ATCN)
_____ %	Trauma Care after Resuscitation (TCAR)
_____ %	Other: _____

11. Describe any trauma competencies/education your hospital requires for your ED nursing staff **above and beyond** the State required continuing education hours and TNCC.

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12. Fill out table for ED Physician coverage (Table C).

13. Fill out ED Checklist (Table D).

**B. Radiology**

1. Is there a radiology technologist available 24/7?

☐ Yes ☐ No

2. What hours do you have a technologist in-house?

AM to PM Monday – Friday  
AM to PM Weekends

3. Do you have a CT scanner?

☐ Yes ☐ No

a. If yes, size? \_\_\_\_\_ slice

b. Do the technologists have cross training in CT?

☐ Yes ☐ No

c. Do you have resuscitation equipment in your CT scanner?  
(Adult & pedi Ambu® bags, suction equipment, O2)

☐ Yes ☐ No

d. Where is the nearest crash cart to your CT scanner?

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4. Radiologist:

a. Do you have a Radiologist on staff (not via teleradiology)?

☐ Yes ☐ No

b. If yes, do they attend a minimum of 50% of Trauma Peer Review Meetings where patient care is discussed?

☐ Yes ☐ No

c. If yes, hours they are in-house?

AM to PM Monday – Friday  
AM to PM Weekends

d. Do you have a Radiologist available by teleradiology?

☐ Yes ☐ No

5. What is the average time to obtain a radiologist reading of an X-ray?

6. Do you have a PI process to monitor changes to interpretation between preliminary and final reads? ☐ Yes ☐ No

If yes, please describe:

**C. Operating Room**

1. Do you have Operating Rooms at your hospital that are utilized for emergent trauma patients (i.e. not routine, scheduled cases)? ☐ Yes ☐ No

a. If yes, fill out OR/Post-Operative Recovery Room checklist (Table E)

b. If no, skip to Section D

2. If yes, number of operating rooms:

3. If yes, do you monitor response times for on-call OR staff? ☐ Yes ☐ No

4. If yes, does your OR staff receive any additional trauma related education such as TNCC? ☐ Yes ☐ No

If yes, please describe:

5. If yes, do you have a Post-Operative Recovery Room? ☐ Yes ☐ No  
If no Pediatric Anesthesia Care Unit (PACU), where do you recover post-op patients?

6. **If yes, do you have equipment for monitoring and resuscitation in PACU?** ☐ Yes ☐ No

7. If yes, does your PACU staff receive any additional trauma-related education such as TNCC? ☐ Yes ☐ No

If yes, please describe:

**D. ICU (Intensive Care Unit)**

Does your hospital have an ICU that is utilized for trauma patients? ☐ Yes ☐ No

1. If yes, Number of beds:

2. If yes, is there equipment for monitoring and resuscitation? ☐ Yes ☐ No

3. If yes, does your ICU staff receive any additional trauma related such as TNCC or TCAR? ☐ Yes ☐ No

If yes, please describe:

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**E. Clinical Laboratory**

1. Is there a laboratory technologist available 24/7? ☐ Yes ☐ No
2. What hours do you have clinical lab capabilities in-house?  
AM to PM Monday – Friday  
AM to PM Weekends
3. Does your lab have capability for standard analysis of:  
☐ Blood  
☐ Urine  
☐ Body fluids  
☐ Microsampling
4. Do you have two or more units of O negative blood in stock? ☐ Yes ☐ No  
If no, what is your process for obtaining emergency blood products?
5. Do you have a process for emergency release of uncrossmatched blood in which nursing staff can access blood prior to arrival of blood bank personnel? ☐ Yes ☐ No
6. How many units of blood does your hospital stock on a routine basis?  
O negative:  
O positive:  
A negative:  
A positive:  
B negative:  
B positive:  
AB negative:  
AB positive:  
Fresh Frozen Plasma:  
Platelets:

**F. Pediatric Care**

1. Do you have pediatric resuscitation equipment in ED? ☐ Yes ☐ No
2. Do you have a Pediatric Intensive Care Unit in-house ☐ Yes ☐ No  
If no, please describe your transfer process for patients requiring Pediatric ICU including names of facilities to which these patients are transferred.

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3. Do you have pediatric-specific audit filters for performance improvement? ☐ Yes ☐ No

**G. Respiratory Therapy**

1. Do you have Respiratory Therapy Services? ☐ Yes ☐ No  
If yes, what hours are they in-house?  
AM to PM Monday – Friday  
AM to PM Weekends

2. Are they on-call after hours?

☐ Yes ☐ No

#### H. Rehabilitative Services

1. Do you have the following services in-house?

Physical Therapy

☐ Yes ☐ No

Occupational Therapy

☐ Yes ☐ No

Speech Therapy

☐ Yes ☐ No

Social Work

☐ Yes ☐ No

2. Describe your transfer process for patients who require admission to an Acute Rehabilitation Center.

#### I. Burn Patients

Describe your transfer process for burn patients requiring a Burn Center including names of facilities to which these patients are transferred.

#### J. Spinal Cord Injuries

Describe your transfer process for spinal cord or head injured patients including names of facilities to which these patients are transferred.

#### K. Acute Hemodialysis:

1. Do you offer hemodialysis in-house?

☐ Yes ☐ No

If no, please describe your transfer process for patients requiring hemodialysis including names of facilities to which these patients are transferred.

### VI. EDUCATIONAL ACTIVITIES/OUTREACH PROGRAMS

A. Do you have any integrated/affiliated specialty residency programs?

☐ Yes ☐ No

If "Yes," list and define any relationship with trauma program.

B. Does your hospital pay for physicians and nurses to attend trauma education? ☐ Yes ☐ No

If yes, what classes? ☐ ATLS ☐ TNCC/ATCN ☐ PALS/ENPC

☐ Trauma Symposia ☐ Other (please list classes)

**C. Describe any trauma education programs your hospital hosts for the following:**

(do not include programs that the hospital pays for (question C above) but does not actually host)

Physicians

Nurses

Pre-hospital providers

**C. Do you provide patient follow-up to EMS?**

☐ Yes ☐ No

**VII. PERFORMANCE IMPROVEMENT (PI)**

Do not send any performance improvement documents or minutes. These should be available at time of review.

**A. Does your hospital have a Hospital PI/QA program?**

☐ Yes ☐ No

**B. Does your hospital have a Trauma PI/Quality Assurance (QA) program?**

☐ Yes ☐ No

If "Yes", list all trauma PI filters (including EMS, pediatric and/or inpatient)

EMS:

ED:

Pediatric:

Inpatient (admissions):

**C. Who does this Committee report to?**

☐ Hospital Quality ☐ Medical Executive ☐ Nursing ☐ Other:

**D. Does your hospital have a written Trauma PI process/policy?**

☐ Yes ☐ No

1. If yes, attach copy to questionnaire.

2. If no, describe your process for review of trauma patient care (include how EMS, ED, transfer and in-patient issues are identified, tracked and loop closure is achieved as well as who conducts these reviews).

**E. Who is responsible for loop closure of both system and peer review issues?**

☐ TNC ☐ TMD ☐ Quality Office ☐ Other: \_\_\_\_\_

**F. Multi-disciplinary Trauma PI Committee:**

1. How often does this committee meet?  
☐ Monthly ☐ Quarterly ☐ Bi-annually ☐ Yearly
2. Who Chairs this meeting?  
☐ TNC ☐ TMD ☐ Other:
3. Membership:  
☐ TNC ☐ TMD ☐ ED Manager ☐ Radiology ☐ Laboratory  
☐ EMS ☐ Quality Office ☐ Nursing ☐ Other: \_\_\_\_\_
4. Is there required attendance? ☐ Yes ☐ No  
If yes, what is the requirement?

5. Describe the scope of this meeting? (i.e. address systems issues, case reviews, review of statistics, etc.)

- G. Are nursing issues reviewed in the trauma PI process?** ☐ Yes ☐ No  
If "No," please describe how nursing units ensure standards and protocols are followed on their units.

- H. If trauma patients are admitted to your hospital, do you have inpatient PI filters?** ☐ Yes ☐ No

- I. How is Trauma PI integrated into Hospital PI/QA?**

- J. Trauma Peer Review Committee**

Do you have a meeting where physicians and APPs review morbidity and mortality of trauma patients? (NOTE: this may be conducted within another hospital meeting such as Medical Executive Staff Meetings) ☐ Yes ☐ No

- a. If no, where do physicians and APPs review the care of trauma patients?

- b. If yes, in what meeting is it conducted?

- c. If yes, who attends?  
☐ TMD ☐ Physicians ☐ APPs ☐ TNC ☐ Other:
- d. If yes, is there a minimum of 50% required attendance for the TMD? ☐ Yes ☐ No
- e. If yes, how often does this committee meet?  
☐ Monthly ☐ Quarterly ☐ Bi-annually ☐ Yearly
- f. If yes, are minutes recorded for this meeting in a separate section devoted to trauma? ☐ Yes ☐ No
- g. If yes, how is information from this meeting relayed to the TNC?
- h. If yes, Who does this Committee report to?  
☐ Hospital Quality ☐ Med Exec ☐ Board of Directors ☐ Other:
- i. Is there a mechanism in place for charts to be sent to an outside reviewer? ☐ Yes ☐ No

**K. Trauma Death Audits**

1. How many trauma deaths have there been during the last fiscal year? (Include DOA, ED deaths, and in-house deaths).  
  
Deaths: \_\_\_\_\_ Dead on Arrival (DOA)  
          \_\_\_\_\_ ED  
          \_\_\_\_\_ In-hospital (includes OR)
2. Do you currently categorize your deaths as: ☐ Yes ☐ No  
Mortality without Room for Improvement,  
Anticipated Mortality with Room for Improvement or  
Unanticipated Mortality with Room for Improvement?
3. If yes, please list below (Have all of these charts available at the time of review.)  
\_\_\_\_\_ Mortality without Room for Improvement  
\_\_\_\_\_ Anticipated Mortality with Room for Improvement  
\_\_\_\_\_ Unanticipated Mortality with Room for Improvement
6. If an autopsy is done by the coroner, do you have a mechanism to get the reports?

**L. Trauma Registry**

1. Do you have a trauma registry? ☐ Yes ☐ No
- a. If Yes, how many months/years are complete for review?
- b. If Yes, what registry program are you using?

☐ Image Trends      ☐ Other (please specify)

2. Who extracts data from the charts and enters it into the registry?

3. What is your average time lapse from date of discharge to entrance into the registry?

4. Describe the criteria for patient entry into the trauma registry (ICD 9/10 codes, admission, transfers, deaths).

5. Do you send your data to the state? ☐ Yes ☐ No

6. Do you use the registry to support the Performance Improvement Program? ☐ Yes ☐ No  
If "Yes," please explain types of activities and provide examples at the visit.

**VIII. PREVENTION ACTIVITIES**

Does the hospital coordinate or participate in Community Trauma Prevention Activities? ☐ Yes ☐ No  
(please have a spreadsheet available at the visit)

**IX. REGIONAL AND STATE ACTIVITIES**

Does your hospital participate in state and regional activities.  
If yes, briefly describe.

☐ Yes ☐ No

\_\_\_\_\_  
Signature of person filling out questionnaire

\_\_\_\_\_  
Title of person filling out questionnaire



## **Table A**

### **GENERAL/TRAUMA SURGEONS**

List all general surgeons currently taking trauma call or covering ED

<b>Name</b>	<b>Attendance at Trauma Peer Review Committee (%)</b>	<b>Residency where and when completed</b>	<b>Board Certified (type and year)</b>	<b>ATLS: Instructor/ Provider Status &amp; Date of Expiration</b>	<b>Number of trauma CME hours in last 4 years-hours</b>

**Table B**

**ANESTHESIOLOGY**

Please list all Anesthesiologists and/or CRNA’s that provide services for trauma patients

<b>Name</b>	<b>Attendance at Trauma Peer Review Committee (%)</b>	<b>Residency where and when completed</b>	<b>Board Certified (type and year)</b>	<b>ATLS: Instructor/ Provider Status &amp; Date of Expiration</b>

## **Table C**

### **EMERGENCY DEPARTMENT COVERAGE**

Please list Physicians and APPs providing ED coverage (include locum tenens)

<b>Name</b>	<b>Attendance at Trauma Peer Review Committee (%)</b>	<b>Residency where and when completed</b>	<b>Board Certified (type and year)</b>	<b>ATLS: Instructor/ Provider Status &amp; Date of Expiration</b>

## **Table D**

### **Emergency Department Checklist**

<b>CATEGORIES</b>	<b>Basic Trauma Center</b>	<b>Check if requirement met</b>
Heliport or Landing Zone Located Close Enough to Permit the Facility to Receive Or Transfer Patients By Air		
Equipment For Resuscitation for Patients of all Ages		
Airway Control and Ventilation Equipment		
Drugs Necessary for Emergency Care		
Pulse Oximetry		
Suction Devices		
Electrocardiograph-Oscilloscope-Defibrillator		
Qualitative End-Tidal CO2 Determination		
Standard IV Fluids and Administration Sets		
Large Bore Intravenous Catheters		
Airway Control/Cricothyroidotomy		
Thoracostomy (chest tube)		
Broselow® Tape		
X-ray Availability 24/7		
Thermal Control For Patient		
Communication with EMS Vehicles		

## **Table E**

### **OR/Post Operative Recovery Room Checklist**

<b>CATEGORIES</b> <b>(Optional - complete only if OR is used for emergent trauma patients)</b>	<b>Check if meet requirement</b>
<b>OPERATING ROOM</b>	
Personnel Available within 30 Minutes 24/7	
Age Specific Equipment	
Thermal Control for Patient	
Thermal Control for Fluids And Blood	
Rapid Infuser System (may share with Emergency Department)	
<b>POST ANESTHETIC RECOVERY ROOM (SICU is acceptable)</b>	
Registered Nurses Available 24-Hours/Day	
Monitoring Equipment	
Pulse Oximetry	
Thermal Control	